
THE HABIT
ALCOHOL & DRUG ABUSE DIVISION
Montana Department of Corrections and Human Services
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TOLL FREE NUMBER 1-800-45-RADAR

This number provides a prevention clearinghouse for Montana. It will provide information and pamphlets and answer questions on prevention or treatment. An answering machine answers at night.

March 1992

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ARTICLES IN THIS ISSUE:

The Department of Corrections and Human Services, Alcohol and Drug Abuse Division, is proposing changes in the chemical dependency services provided at Galen. What follows are the changes currently being considered by the Department. **We invite your review and written comment on this proposed plan.**

NARRATIVE
CHEMICAL DEPENDENCY PROGRAM REORGANIZATION
GALEN CAMPUS

In order to ensure quality chemical dependency services in the most cost effective manner to residents of the state of Montana the Department of Corrections and Human Services is proposing to reorganize chemical dependency treatment services at the Galen Campus. Presently the following chemical dependency services are offered:

1. Detoxification in the acute care hospital.

2. 72 bed - 28 day inpatient program at the Alcohol Service Center.

3. 15 bed- 90 day inpatient drug treatment program at Lighthouse.

Chemical Dependency is a PRIMARY ILLNESS that can be put into remission by abstaining from the use of MOOD ALTERING CHEMICALS, individualized treatment planning, education and long range continuing care. Inherent in the concepts and practice of chemical dependency services at ASC and Lighthouse is a team approach sensitive to the belief that the patient suffers from a DISEASE that requires consistent, empathetic, supportive and structured treatment. These programs comply with all local and state requirements for the treatment of Chemical Dependency. Participation in self help groups such as A.A., N.A. etc.. is strongly encouraged. Our goal is to facilitate PERSONAL RESPONSIBILITY for growth and change in each individual's transition to chemically free living.

The following concerns provide rationale for the recommended reorganization:

- Too few counselors at ASC to provide adequate 24 hour a day supervision and treatment (12-1 client/counselor ratio.)

- Increasing number of clients who are inmates or referred from the criminal justice system. (Approximately 70% inmates or non voluntary clients in FY 91.)

- Minimal evening and night coverage at ASC; (one LPN from 11:00 pm to 7:00 am; one certified counselor from 4:00 pm to 11:00 pm.)

- Waiting list at ASC of 30 days for men and 70 days for women.

- Low completion ratio for Lighthouse clients.

- Lack of sufficient number of clients motivated for 90 day program.

- Low percentage of clients who make successful transition to community aftercare resulting in relapse into active chemical dependency.

- Non availability of a short term program at Galen.

The reorganized chemical dependency programs at Galen would offer four specialized programs for the treatment of Alcoholism and Chemical Dependency which will help alleviate many of our concerns. These programs will utilize all existing chemical dependency treatment staff and the current 87 beds that comprise Lighthouse and ASC.

* D.E.A.R.: (detoxification, education, assessment and referral). Once detoxified those individuals motivated for treatment will participate in a 4 to 5 day education and assessment process to prepare them for referral and placement in the least restrictive environment that meets their specific needs.

* Short Term Care: A maximum two (2) week residential program, providing an intervention process for individuals who will be entering community based intensive outpatient program (IOP) and are in need of work on their denial and motivation. Also relapse-specific counseling for those individuals with a history of treatment and sobriety, who demonstrate a desire to work through their relapse issues and return to the community and out-patient care as soon as possible.

* Primary Care: A traditional 28 day program with primary focus on chemical dependency, utilizing the first five steps of Alcoholics Anonymous coupled with Reality Therapy, R.E.T., Behavior Modification, group and individual therapy.

* Extended Care: A maximum sixty (60) day residential program for the individual with a history of repeated treatment failures, that is in need of a more intensive longer term setting coupled with long range after-care planning that may include transitional living, half-way house or some other structured living situation within the community upon completion of treatment.

INTAKE/ADMISSION

The referent (which may be self, family, out-patient clinic, legal and court system, etc.) may contact the Intake Specialist (hours are Monday through Friday from 8:00 am to 4:00 pm) to arrange an admission date and time. It is however suggested that the potential patient be assessed and referred by a state approved chemical dependency program within the individual's home community. (NOTE: The acute care hospital is mandated by law not to refuse individual access to the detoxification program). The Detoxification program is a full service program and patients are admitted 24 hours a day 7 days a week. All patients entering the continuum of services provided must enter the system by way of the detox program. Once the patient is determined to be medically stable the person will be given the opportunity to continue the D.E.A.R. process. If the patient is unwilling alternative recommendations will be made back to the community or source of referral. Each patient entering the program will be interviewed by the reimbursement officer so that a financial status can be determined. Treatment costs are based on a individual's ability to pay and the necessary arrangements will be made with the officer at the time of the interview.

Admission criteria:

1) Must be 18 years of age and older.

2) May be of either sex.

3) May be referred on a voluntary or involuntary basis.

4) Must have a primary diagnosis of Alcoholism and/or Chemical Dependency.

5) If pregnant the Intake Specialist must be informed and a referral may be made to a community based inpatient chemical dependency program.

6) Must be ambulatory and without a primary medical diagnosis that would interfere with the patient receiving full benefit from the program.

DESCRIPTION OF COMPONENTS

I. DEAR
Detox + 4-5 days for Education Assessment and Referral

GOAL: TO PROVIDE TIMELY AND COMPREHENSIVE A) DETOXIFICATION B) EDUCATION C) ASSESSMENT and D) REFERRAL which is based on the individual's specific needs and maintains a least restrictive focus.

A. DETOXIFICATION

OBJECTIVES

1) Provision for 24 hour public access to Detoxification.

2) Completion of a medical history and physical examination on each patient.

3) Recommendations as to the patient's physical and psychiatric status will be made and included into the patient initial treatment plan.

4) Detoxification services for patients in the detoxification unit.

5) When the patient's condition is considered medically stable a physician's order will be written for the patient's participation in the remainder of the DEAR process, with an average length of stay (LOS) of 4 to 5 days. If the patient is unwilling to accept this order/recommendation an alternative recommendation and transportation will be arranged prior to discharge.

B. EDUCATION (refer to DEAR schedule)

OBJECTIVES

1) Provision for lectures by the DEAR counseling staff on the following: a) Disease Concept; b) Defenses and Feelings; c) Whole person illness; and d) First step of A.A.

2) Provision of daily counselor-facilitated group session in which information is processed on a personal level.

3) Provide video programs on topics specific to the patient population.

4) Weekly closed AA meetings with AA volunteers.

5) AA/Recovery literature along with audio tapes.

C. ASSESSMENT (methods of the process)

OBJECTIVES

1) An initial interview will be completed by a counselor which will include the following: a) drug and alcohol history; b) previous treatment history; c) legal history; and 4) psychosocial history.

2) A questionnaire will be sent out to family and others who have pertinent client information.

3) Appropriate data will be collected from the legal system if admission is court related and/or such information is found necessary.

4) A medical history and physical provided by medical staff.

5) The use of diagnostic tool (i.e., CD2 and others).

6) A self-assessment process which interfaces the education process.

7) Other resources (e.g., previous treatment records, etc.).

D. REFERRAL (least restrictive approach)

OBJECTIVES

1) Utilization of a Managed Care System with appropriate placement criteria based on individual needs.

2) Utilization of a Multi-Team approach in the development of an individualized plan.

3) Active patient participation in a clinical staffing in which recommendation/referrals will be presented.

4) Referrals/placements facilitated by appropriate staff members.

5) The least restrictive approach will be utilized and referrals may be made to state approved community based programs or services within the CONTINUUM of CARE offered at Galen.

II. **SHORT TERM CARE** - 9 Beds
14 days length of stay
1 chemical dependency counselor 9-1 ratio

ADMISSION CRITERIA:

1) Patient must have completed the D.E.A.R. process and found appropriate for the program.

2) Patient must demonstrate a willingness to actively participate in the program.

3) Patient must have a supportive environment to return to upon completion of the program (i.e. family, employment, availability of community resources, etc.).

4) Patient must be willing to commit to enter an Intensive Out-Patient program and/or follow other recommendations as appropriate.

GOAL: Provide a maximum two (2) week in-patient treatment program to serve individuals who:

1) Have been referred by the DEAR program.

2) Do not have a previous treatment history, and is demonstrating a) lack of insight b) questionable motivation for treatment and/or recovery c) a need for intervention to work through issue of DENIAL and DELUSION d) Once motivated will enter a state approved I.O.P.

3) Have a history of previous treatment and sobriety and in need of relapse counseling along with a highly structured after-care plan.

OBJECTIVES:

1) To provide an initial interview conducted by the individuals primary counselor to assess needs and approach.

2) To provide an individualized master treatment plan utilizing a WHOLE PERSON approach.

3) To provide individualized counseling.

4) To provide daily group therapy with both populations.

5) To provide educational information to meet the specific needs of the patient.

6) To utilize FIRST STEP A.A. principles to aide the patient in identifying their personal issues of POWERLESSNESS and UNMANAGEABILITY.

7) To provide RELAPSE counseling utilizing "GORSKY MODEL".

8) To provide discharge planning groups to develop a realistic care plan utilizing community based resources.

9) To provide availability of in-hour A.A. meetings along with other mandatory program activities (i.e. lectures, recreation, special groups, etc.).

10) To provide an opportunity for self examination and re-direction.

III. **PRIMARY CARE** - 60 Beds
28 length of stay
6 chemical dependency counselors 10-1 ratio

ADMISSION CRITERIA:

1) Patient must have completed the D.E.A.R. process and have been found appropriate for the program.

2) Patient may or may not have a history of both in-patient or out-patient treatment.

3) Patient has a home and/or community environment that is non-supportive.

4) Patient lacks the resources to take part in an out-patient program (i.e. lack of transportation, lack of services in the home community, etc.).

5) Patient has a recent history of an inability to maintain sobriety and has demonstrated poor motivation to follow through with the necessary lifestyle changes.

GOAL: Provide a maximum 28 day primary in-patient treatment program utilizing a 12 step approach for poly drug dependent individual with a strong emphasis on the first four (4) steps of A.A., discharge and aftercare planning.

OBJECTIVES:

1) To provide a twelve (12) approach to recovery.

2) To provide an individualized treatment plan.

3) To provide individual therapy.

4) To provide group therapy.

5) To provide education in the form of lectures, videos, reading assignments, discussion groups and written assignments about their illness and related recovery issues.

6) To provide special didactic groups on topics such as anger/resentment, grief, assertiveness training, communication skills, family issues, etc.

7) To provide the patient with an opportunity for recreation and develop alternative free time leisure activities.

8) To motivate patients to assume personal responsibility and commitment for recovery.

9) To help the patient to develop a realistic aftercare plan facilitating placement in services offered in the home community.

IV. **EXTENDED CARE** - 18 Beds
60 day length of stay
2 chemical dependency counselors 9-1 ratio

ADMISSION CRITERIA:

1) Patient must have completed the D.E.A.R. process and be found appropriate for the program.

2) Patient has a treatment history of two (2) or more episodes in the past two (2) years.

3) Patient has demonstrated an inability to maintain abstinence and make the appropriate lifestyle changes.

4) Patient has a current history of unemployment.

5) Patient is currently living in a non-supportive environment.

6) Patient presents issues that interfere with maintaining a recovery lifestyle.

7) Patient is a good candidate for placement in a transitional living situation upon discharge.

GOAL: To provide an extended residential care program with a maximum length of stay of sixty (60) days that:

1) Will focus on the problem areas that the patient and staff have identified as major issues that affect the patient's ability to remain chemically free and make the necessary lifestyle changes.

2) Will utilize a WHOLE PERSON approach in the individualized treatment plan.

3) Will help the patient to become motivated and committed to completely invest in their recovery by taking responsibility.

4) Will facilitate the patient aftercare plan to utilize the communities resources in their optimum.

5) Will provide an opportunity and alternative to outpatient and primary treatment that has been attempted.

OBJECTIVES:

1) To provide a stable and consistent daily treatment schedule.

2) To provide a structure where the patient is held accountable to assume responsibility for their program of change by:

   a) active participation in individual and group therapy that occurs on a daily basis;

   b) active participation in AA/NA a minimum of three times a week held on the treatment unit;

   c) active participation in study groups that focus on subjects such as AA, principals, relationships, stress management, spirituality, etc.;

   d) completion of journaling exercises and written assignments;

   e) completion of an anger management workshop;

   f) completion of a relapse workshop;

   g) working steps one (1) through ten (10) of the AA program;

   h) participation in lectures offered by the CDU staff.

3) To provide an opportunity for family participation in the form of education, referral and conferences.

4) To offer opportunities to participate in Vocational Rehabilitation services.

5) To offer G.E.D. education and testing when appropriate.

6) To provide recreational activities and leisure planning.

7) To facilitate structured aftercare planning and placement.

In FY 91 there were approximately 1,040 admissions to treatment at the Alcohol Service Center and Lighthouse Drug Program. We believe that we can increase the number of people served by over 10% under the proposed reorganization plan. All clients would be served in a more effective and protected environment utilizing the existing 87 licensed treatment beds and all current treatment staff.

For More Information, Contact:
Roland Mena - Director
Residential Chemical Dependency Services
Warm Springs, MT 59756-9999
693-7360

OR
PLEASE

Send written comments to:
Darryl L. Bruno - Administrator
Alcohol and Drug Abuse Division
Department of Corrections and Human Services
1539 11th Avenue
Helena, MT 59620-1301

ADVISORY COUNCIL RE-AUTHORIZED

The Montana Advisory Council on Chemical Dependency has been continued. This Council, which meets quarterly, provides input to the Department on treatment and prevention activities in each of the five Health Planning Regions. There are two members appointed from each Health Planning Region for a total of ten members. The current members, appointed by the Director to serve at the pleasure of the Governor, are:

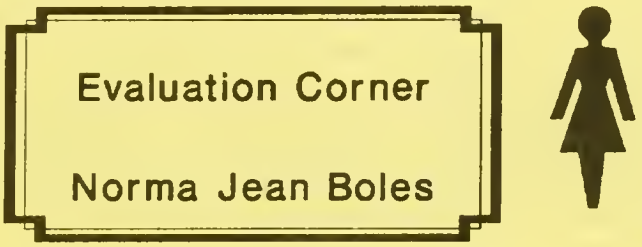
NAME	ADDRESS
Sandra Lambert, R.N. Representing Health Region I	816 South Center Miles City, MT 59301
Carole Carey, Clerk of Court Representing Health Region I	Box 322 Ekalaka, MT 59324
Jim Gamell, School Counselor Representing Health Region II	Great Falls Public School P.O. Box 2423 Great Falls, MT 59403
Curtis C. Moxley, County Commissioner Representing Health Region II	Route 70, Box 47 Chinook, MT 59523
Terry Dennis, M.D. Alcohol Coordinator Indian Health Service Representing Health Region III	P.O. Box 2143 Billings, MT 59103
Patrick Wolberd, MSW Representing Health Region III	2417 Elizabeth Street Billings, MT 59102
Marco Lucich, Juvenile Parole and Probation Officer Representing Health Region IV	131 Rocky Mountain Lane Butte, MT 59701
Carol Judge, R.N., CCD Counselor Representing Health Region IV	1802 Lockey Street Helena, MT 59601
Dana L. Christensen, Attorney Representing Health Region V	P.O. Box 759 Kalispell, MT 59901
Rep. Steve Benedict, State Legislator Representing Health Region V	P.O. Box 668 Hamilton, MT 59840

We wish to thank Rep. Tom E. Lee of Bigfork and Rod Robinson of Great Falls for their service. Replacing them on the Advisory Council are Rep. Steve Benedict and Terry Dennis, M.D.

IMPORTANT NOTICE

The Department of Corrections and Human Services is issuing two Requests for Proposals. One of these proposals, with a March 28th due date, is for an incident and prevalence study on gambling in Montana. This RFP is at the request of the Department of Justice Gambling Control Division. The second proposal is for a study on the availability of effective treatment resources in Montana for persons suffering from gambling addiction and the minimum requirements for certification of persons providing counseling for gambling addiction. Included in this study is a survey of practitioners in Montana, a review of literature on gambling treatment and a review of standards. The due date for this proposal will be in April.

For more information and a copy of the Request for Proposals, contact Norma Jean Boles at the Department. You may call her at 444-4931.



STANDARDS AND QUALITY ASSURANCE

Status of Rules

Draft standards are developed and have been sent for approval to the Director's office for: patient placement criteria, expanded utilization review, intensive outpatient treatment, and day treatment.

Patient Placement Criteria

Rules to implement 53-24-215 (HB 909), the law changing the eligibility requirements for CD counselor certification, are in the process of development.

Changes to Evaluation Schedule

ADAD will provide biennial (2-year) evaluations to state approved alcoholism programs scoring over 80% in all components. Programs to remain on the annual schedule are: Programs receiving scores less than 80%, programs with new components, contracts provisions, restricted approval, programs exhibiting significant change, or programs about which a complaint has been received.

PACT

The Project for Addiction Counselor Training (PACT) was created in response to the need for additional substance abuse counselors. It is a federally funded project sponsored by the Office for Treatment Improvement, and is implemented through a contract to the National Association of State Alcohol and Drug Abuse Directors. It was designed to provide career development opportunities to increase the number of credentialed counselors nationwide. Tuition-free opportunities that include coursework as well as internship experiences are provided to eligible PACT applicants, priority given to persons from minority and special populations, through training vendors across the country. All training services delivered meet individual state requirements.

Presently, 31 vendors have been identified to provide services in 46 states and territories. The Montana Deaconess Medical Center Chemical Dependency Unit Counselor Training Program in Great Falls is the PACT Training provider in Montana.

PACT enrollees must have a high school or GED equivalent, have less than three years of alcohol or drug work experience, and have no history of alcohol or other drug misuse or dependency for a period of two years immediately prior to participation in this Project. Any person who meets the criteria and is seeking job placement in a licensed treatment facility as a certified addiction counselor is eligible. Information regarding application is available at the program and the Alcohol and Drug Abuse Division.

STATE PLAN

Every four years the Alcohol and Drug Abuse Division undertakes a complete revision of the State Chemical Dependency Plan. The completed planning document is the foundation for the provision of treatment, early intervention and prevention services. This process begins with the submission of county plans. The process continues with Departmental review of the county plans, review of pertinent Federal guidelines and review of the document by the Montana Advisory Council on Chemical Dependency. The final step in this process is citizen review. The new proposed state plan is available for review. We will be making copies available upon request. At this time, oral or written comments will become part of the public record. In addition, we will hold a public hearing in Helena on April 13th at 1:30 p.m. in the large conference room at the Department. If you wish a copy of the draft state plan or more information on the hearing, please write Marcia Armstrong at the Department of Corrections and Human Services, 1539 11th Avenue, Helena, MT 59620. You may also call her at 444-2878.

CDPM CORNER

By Mike Ruppert, President
Chemical Dependency Programs of Montana

Chemical Dependency Programs of Montana is an organization consisting of the directors of the major in-patient and out-patient programs in the state. Recently, the major concerns of the organization have focused around funding of services. We have been busy preparing for the next regular session as well as negotiating with Blue Cross regarding their new "HMS" in-patient admission criteria.

Blue Cross adopted new criteria for in-patient admissions for chemical dependency during October, 1991. Since that time, many in-patient referrals have been denied. Those admitted are often covered for only a few days. The criteria states that in-patient admissions are only possible after out-patient failure (with limited exceptions for physical and psychiatric complications.) The criteria further stipulate out-patient failure had to occur within 90 days of the in-patient admission. This means if someone failed out-patient 6 months ago, he/she would have to be readmitted to out-patient and fail again before being allowed into in-patient. It is unclear at this point who would define out-patient failure -- Blue Cross or the treatment centers. In order to save money, Blue Cross could insist that one or two relapses do not constitute failure (they have admitted this is a possibility.) Would programs allow Blue Cross criteria to dictate treatment philosophy? For example, numerous relapses are O.K. Or, would the programs discharge these clients knowing they could not be referred to in-patient because they hadn't failed according to Blue Cross? If one of these discharged clients had an accident while driving under the influence, would the out-patient program be liable?

Similarly, those requiring in-patient as their first treatment would have to fail at out-patient first. Consider, for example, an adolescent experiencing gross denial. Do out-patient programs have to admit adolescents into their adult IOP programs to accommodate Blue Cross out-patient failure requirements? Most cities in Montana are not big enough to support a specialized adolescent IOP program. Imagine the effects of a couple of 13 year-olds in an adult group. In addition, out-patient programs will be forced to accept persons into treatment whose behavior will disrupt the treatment of those people who are motivated to be there.

CDPM has been meeting with representatives of Blue Cross in order to develop a system that is more responsive to client/patient needs. Thus far, negotiations have gone well. However, we are still far from a system that is acceptable to both sides.

The adoption of managed care admission criteria has not been unexpected, in fact a managed care regulation bill was passed during the last regular session. The criteria adopted by Blue Cross have the potential to cause massive changes to treatment systems in Montana. Unfortunately these changes will not always be in the best interest of individuals in need of treatment services for chemical dependency.

CDPM Corner does not necessarily reflect the views of the Alcohol and Drug Abuse Division of the Department of Corrections and Human Services. This regular feature is provided to keep our readers informed on the views of the private sector.

THIRD ANNUAL DRUG TEST FOR MEMBERS OF CONGRESS (Answers: Page 30)

1. Since 1986, the US Customs Service has spent more than $100 million to test, build and deploy seven radar balloons on the US-Mexican border. How many smugglers have been caught in the effort?

   a. More than 5,000
   b. about 2,000
   c. 942
   d. Less than 50

2. Last year, the Massachusetts National Guard:

   a. Patrolled the Atlantic Ocean looking for drug smugglers.
   b. Attended a Grateful Dead concert to try to identify suspicious looking people.
   c. Were sent to Peru to eradicate coca plants.
   d. Discovered a marijuana field the size of Boston.

3. In 1989, sailing a combined 2,347 ship days costing $33.2 million, the US Navy and Coast Guard:

   a. Seized 879 ships and arrested 2,368 drug smugglers.
   b. Seized 637 ships and arrested 1,472 drug smugglers.
   c. Seized 348 ships and arrested 856 drug smugglers.
   d. Seized seven ships and arrested 40 drug smugglers.

4. Three of the following statements are true. Which statement is false?

   a. Enough urine is tested each year to fill Lake Michigan.
   b. Two ounces of a particular diet soda held under the arm for one hour will be accepted as a valid urine sample 98% of the time.
   c. Adding a brand of eyedrops to a urine sample camouflages any trace of marijuana in a drug test.
   d. Cocaine users can avoid detection by simply adding bleach to urine.

5. According to the Bush Administration, the typical cocaine user is white, male, a high school graduate, employed full time and living in the suburbs.

   a. True
   b. False

6. The Dutch have a far lower per capita consumption of drugs than the United States. Who wrote: "The fundamental difference in Dutch drug policy is its demand-oriented approach to the problem as opposed to the supply-oriented approach favored by the United States and many other countries?

   a. Reverend Jesse Jackson
   b. The Bush Administration State Department
   c. Vice President Dan Quayle
   d. Roseanne Barr

7. Instead of spending time and effort to catch and prosecute marijuana users, "we should concentrate on prosecuting the rapists and burglars who are a menace to society." Who made this statement advocating the decriminalization of marijuana.

   a. Reverend Jesse Jackson
   b. The Bush Administration State Department
   c. Vice President Dan Quayle
   d. Roseanne Barr

8. For every $1 we spend on treating hard-core drug users, the US taxpayer is saved $3 in reduced crime and other social costs.

   a. True
   b. False

9. Every day 56,000 hard-core addicts seek treatment, but are turned away for lack of staff or space.

   a. True
   b. False

10. Cocaine is the primary ingredient in the coca plant. The biggest legal importer in the United States is...

    a. The federal government
    b. Makers of nicotine chewing gum
    c. Coca-Cola
    d. RJR Tobacco

11. The Bush Administration claims that the US has 862,000 regular cocaine users. How was that number determined?

    a. The total number of "High Times" magazine subscribers
    b. A survey of hospital emergency rooms
    c. The government interview 8,621 people, of whom 65 admitted using cocaine weekly. The number was then extrapolated to account for the total US population.

12. Last year, international drug smugglers placed a $30,000 bounty on the head of "Barco". Who is "Barco"?

    a. The Secret Service code name for the Attorney General
    b. The Director of the Bolivian government police
    c. A US Border Patrol drug-sniffing dog
    d. A mid-level bureaucrat in the Customs Service

THIRD ANNUAL DRUG TEST FOR MEMBERS OF CONGRESS (continued)

13. A recent National Institute of Drug Abuse (NIDA) federal study found:

a. a typical Grateful Dead fan is a white male living in the suburbs.
b. You can blow bigger bubbles with nicotine chewing gum than with regular chewing gum.
c. People who have chocolate cravings and ice cream binges are more likely to become drug addicts.
d. Caterpillars that eat coca plants have constant runny noses and have trouble sleeping.
e. A typical member of Plant and the Guardians (a legendary 60's rock 'n roll band) is a white male living in the suburbs.

14. The inhalant used most by students in exams is a typewriter correction fluid.

a. True b. False

15. In the US last year, the total number of overdose death caused by aspirin was virtually the same as overdose deaths from:

a. Tobacco
b. Heroin
c. Alcohol
d. Typewriter correction fluid

Published by the "Alcohol Research Information Service" 1106 East Oakland Avenue, Lansing, Michigan 48906.

STAY SMART!! PREVENTION CORNER

Ken Taylor

THE PREVENTION ASSISTANCE TEAM

- What is prevention?

Prevention is the pro-active process of creating the conditions and fostering the personal attributes that promote the well-being of people.

- Our vision:

All Montanans will positively contribute to promoting the well-being of themselves and other in their communities.

- Our mission:

The Montana Prevention Assistance Team pro-actively promotes community participation in building collaborative prevention systems throughout Montana.

- What is the Prevention Assistance Team?

PAT is a loose interagency association of some 40 facilitators of the 1990 Caring for Kids Conference; this conference provided the opportunity for communities in the five Health Planning Regions to work together. The PAT **supports this joint effort to create a statewide prevention system;** its goal is to help communities collaborate to develop their own culturally-relevant ways of addressing local issues. The PAT is also building a network which can offer technical assistance, consultation and referral services to local Montana communities.

- PAT Membership

Prevention Assistance Team members include **state agencies:** the Montana Departments of Corrections and Human Services, Family Services, Health and Environmental Services, Justice, Board of Crime Control and Office of Public Instruction.

PAT also includes **public and private non profits:** Montana Children's Trust Fund, Center for Adolescent Development, Montana Communities in Action for Drug-Free Youth, Montana 4-H, Montana Council for Families, Missoula City/County Health Department, Healthy Mothers Healthy Babies, Parents Let's Unite For Kids, Coordinator of Indian Affairs and Montana United Indian Alliance.

THE NEW APPROACH TO PREVENTION

(The following is excerpted from The Montana Prevention Assistance Team Vision Document, drafted by Kirk Astroth. For the full text, contact Kirk at Montana State University, or call ADAD).

Over the past 20 years prevention thinking and strategies have changed considerably. Social problems are now viewed as sharing a common basis of environmental factors working simultaneously. This new paradigm no longer sees **agencies and professionals** as solely responsible for solving community concerns. Instead, **their role shifts to one of working to help the community acquire and use resources necessary to respond to its own needs.** The community now becomes the expert, and professionals and agencies work with the community to involve all impacted groups and ethnicities in decision-making. This new model shifts from a service delivery to a **COMMUNITY EMPOWERMENT MODEL.**

PRINCIPLES OF PREVENTION - USING COMMUNITY EMPOWERMENT MODEL:

1. Local people solve local problems.
2. People support what they help create.
3. Change requires action; prevention is not a spectator activity.
4. Teams are more effective than individuals working in isolation.
5. People respond better when they have a vision and direction.

SERVICE DELIVERY MODEL versus COMMUNITY EMPOWERMENT MODEL

WE USED TO:	NOW WE:
Do for the community	Do with the community
See professionals as experts	Use community experts
Deny ethnic and cultural differences	Include ethnic and special populations in program efforts
Plan the programs alone	Include others in the planning process
Focus on the individual	Look at the individual within the key systems that affect their lives (family, peers, schools, work and community) and develop community partnerships

MONTANA COUNCIL ON FAMILIES - submitted by Jeanne Kemmis

The Legislative Interim Committee on Children, Youth and Families has rescheduled its public education forum with the National Conference of State Legislators. The new date is May 7-8 in Helena. This forum will be an opportunity for community representatives to participate with the committee in developing or giving direction to Montana's Prevention policy. For more information contact Andrea Merrill at the Legislative Council (444-3596) or Jeanne Kemmis at MT Council for Families (728-9449).

OSAP NEWS

The federal Office of Substance Abuse Prevention (OSAP), wants to hear from you at:

OSAP
Alcohol, Drug Abuse and Mental Health Administration (ADAMH)
5600 Fishers Lane Room 9A54
Rockville, MD 20857
Phone (301)443-0365

The National Clearinghouse for Alcohol and Drug Information (NCADI) has a bimonthly news bulletin and alcohol/drug awareness service, Prevention Pipeline, for $20.00/yr. NCADI's phone number is: (301)468-2600 x 235. The Chemical Dependency Bureau also has available some of the literature put out by NCADI. Contact Ken Taylor - 444-1202.

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YOUTH AS RESOURCES - submitted by Curt Campbell

The role of young people in our society has deteriorated, if indeed it has even been adequately and appropriately established. Surely those concerned with the future of our nation should readily see this as being the highest of priorities.

The idea of Youth as Resources is directly related to the manner in which adults show responsibility for their part in adult/youth relationships. Whether the setting for these relationships is the family, the school,, or some other youth focused organization, an examination of the quality of those relationships provides insight into the behavior and performance of young people. The patterns of these relationships are part of our culture and are integral to the basic institutions of American society.

When adults respect and involve young people as resources and build this attribute into their behavior, the task of creating better communities will become more apparent and far easier.

REGIONAL PREVENTION SYSTEM TRAINING

In the coming months, the PAT will hold several workshops to help develop the five Regional prevention networks. Through a grant from this Department administered by Montana Communities in Action for Drug Free Youth, some scholarships are available. Plans are for about 40 people per workshop.

Training Schedule:

All dates are for Friday 4:00 - 9:00 p.m. and Saturday 8:00 a.m. to 4:00 p.m.

February 21-22	Region 4	Butte (includes Helena and Bozeman)
February 28-29	Region 2	Havre (includes Great Falls)
March 6-7	Region 3	Billings
March 13-14	Region 5	Missoula (includes Kalispell & Libby)
March 27-28	Region 1	Glendive (includes Eastern Montana)

Training Objectives:

For local prevention efforts to be effective, they need to expand their circle of involvement both geographically and within the social circles of their own communities.

For effective regional prevention, we cannot build prevention efforts one organization or one community at a time.

For effective statewide prevention, all the diverse groups working on prevention in all its profiles, from alcohol and drug abuse, premature sexual activity, school dropouts, tobacco or any other problem, must work together at the local, regional and state levels.

Training Process:

Facilitator Don Petterson is Executive Director of the Peace Studies Institute of Rocky Mountain College. He has some 15 years' experience as a former 4-H agent, working with rural communities in the Billings area. His current areas of expertise are: community building, conflict management and resolution, and communication styles as a function of personality types.

OSAP STATEWIDE TRAINING - for veterans of the Regional training:

The federal Office of Substance Abuse Prevention (OSAP) will offer three additional training opportunities to those involved in the Regional system building sessions above. There is no fee for these workshops but participants must pay their own room and board for sessions exceeding one day. Some subsidies are available. These sessions will not be repeated regionally.

** **Intercultural Communication** Billings

Two part session - Please plan to attend both sessions:
Friday March 20 (9:00 a.m. -6:00 p.m.) and May 1992 (date to be announced).

Facilitator: **Grace Poweless Sage** received her Ph.D. in Psychology from University of Montana and is now on staff at Cornell University.

The first session, planned for a group of about 50 people, will focus on how to join diverse groups into an effective community organization.

** **Training for Trainers:** Two part session:

June 8-12 in Missoula and Fall 1990 (date tba) in Eastern MT, probably Billings.

This week long session will train trainers, as part of OSAP's effort to develop a national core of trainers to work in each state. More information on location and dates will follow.

** **Community Partnership Training** - Great Falls - August 1992 (dates tba)

OSAP will be sponsoring a series of one day trainings related to their community partnership initiative. More information on this training will follow as it becomes available.

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MONTANANS CARING FOR KIDS CONFERENCE - April 9-10

(Wednesday - Thursday) Kalispell Outlaw Inn

The theme of the 1992 Caring for Kids Conference is **"Livin' The Good Life: A Resource Conference on Prevention Strategies for Youth Substance Abuse"**. The conference is for teens and adults. Keynote speaker will be **George Obermeier**; his topic - **"Natural Highs"**. George has been nationally recognized for work in student assistance programs and is Vice President of J. Mayer & Associates, an educational consultant firm promoting wellness and developing human potential. George has published in many professional journals.

The conference schedule includes numerous workshops, a teen dance and a massage technique session on Thursday.

Friday will feature more workshops, and speaker **Cynthia Rowland McClure**. Cynthia is a former award-winning television news reporter, professional lecturer and author of The Monster Within, The Courage To Go On, Life After Addiction, and Food For the Hungry Heart.

Registration must be in by March 6. There must be a chaperon for every four teens registering and there will be **no on-site registration**. Continuing Education credits have been applied for through the Department of Corrections and Human Services, Montana Law Enforcement Academy and the University system. **For more information call Kay Hopkins, CARE Coordinator (406)756-6986 or Montana Communities in Action (406)782-4406.**

FOURTH ANNUAL YOUTH IN CRISIS CONFERENCE - April 22-24

(Wednesday - Friday) Great Falls Sheraton

The theme of the 1992 Conference is **"Surviving Life: The Challenge of Preventing and Overcoming Dysfunction"**. Keynote address at this fourth annual event will be **"Family Therapy Related Issues in The 90s"**, given by Jared Balmer, Ph.D., Executive Director, Rivendell Children and Youth Center of Utah. Other presenters include an array of professionals from Shodair Children's Hospital of Helena, Rivendell of Billings, Montana Mental Health Association, Great Falls Deaconess Medical Center, Alliance for Youth, and NEOWE-TOHOPA, INC. of Great Falls.

The conference features two days of lecture, panel discussion, workshops, and networking. **It was designed especially for school personnel**: administrators, board members, teachers and youth counselors; **and for all others interested in helping youth**: social workers, mental health workers, nurses, emergency and crisis unit personnel, police and corrections staff.

The goal is for participants to focus on issues confronting youth, and to actively engage in the challenge of helping them overcome their dysfunctions. College credit is available and professional points have been applied for. For more information on the conference, contact Curt Campbell at Opportunities, Inc., Great Falls.

SAGE FIRE THEATER

As part of the **Youth in Crisis Conference**, a group of Missoula youth called **Sage Fire Theater** will present the psychodrama **"Well in the Woods"**. Comprised of monologues based on their own lives and lives of their peers, "Well in the Woods" is a social statement in the form of a fairy tale.

The characters explain the pain of growing up experiences in a personal and moving way. Their goal is to be thought-provoking and have the audience see the healing process in motion.

Situations the play touches upon include death of a parent, rejection, child abuse, child sexual abuse and rape. Discussion on the grieving process follows each performance.

Now in its first year, **Sage Fire** Theater is an example of both using youth as resource and the community empowerment model. The cast, from three Missoula high schools and varying from 10-18 members, make all decisions. Their task was to define issues important to them and their peers, to create drama pieces as an alternative to "stuffy lectures by adults who think they know what's important to teens."

Teens were asked to write a script on the topic **high risk behavior**. Says Claudia Marieb, Sage Fire project coordinator, "We thought they'd work on specific high risk behaviors such as alcoholism, teen pregnancy, etc. But they decided to look at the original wounds that may cause the tendency to result in such behavior. They saw the root problem as abuse, and alcoholism, violence and promiscuity as merely symptoms acted out. **Evaluating the success of this project rests on the assumption that addictive behaviors are due to original pain,"** Claudia said.

Funding for this theater project was given because it is a collaborative project, believes Melanie Matelich, teen program director at the Missoula YMCA. The troupe has three adult members; the third is Dana McMurray as drama coordinator. Sage Fire was jointly sponsored by the Missoula YMCA, Department of Health and Environmental Sciences, Missoula Children's Theater, League of Women Voters and Planned Parenthood. **"Funding agencies like collaborative ventures,"** Melanie said. Of three teen project grants proposed by the YMCA, only this was funded. (Peer counseling and career counseling were felt to be duplications of services offered elsewhere).

The group has performed for Missoula Youth Homes, where the response was great; they have also performed in schools and have plans to perform on the University of Montana campus. When performing for young audiences, the players provide a discussion guide and a list of resources in case repressed material comes out in response to the play.

Says Pat Dodson, Executive Director of the YMCA, "As parents, we have as much to learn from our kids as we do to teach them. Sage Fire Theater gives our teens an opportunity to tell us what their experience is." Melanie added that **"funding sources are out there for projects like this."** The thespians plan to reapply for their grant again next year.

REDUCE RISK, ENHANCE RESILIENCY FACTORS FOR EFFECTIVE PREVENTION

by Kirk A. Astroth, Extension Specialist, 4-H Youth Development, Montana State University

Had Abraham Lincoln been born today, he would have been labelled as a child "at risk." For instance:

- Lincoln's parents had only limited education; his father could not read and his mother signed her name with an X.
- The Lincoln family was low income.
- Lincoln's health was poor. He suffered from congenital depression and a baffling melancholia.
- Lincoln's mother died when he was a child causing his father to become a one-parent householder.
- Lincoln was in and out of school, and had less than one year of formal education.

So, how did this "youth at risk" become President of the United States? As with other youth who succeed in the face of seemingly insurmountable negative situations, Lincoln's life was filled with a number of resiliency factors which helped him overcome these risk factors.

Most practitioners in the field of prevention are coming around to the notion that successful prevention efforts do not just focus on personal liabilities but they also focus on enhancing personal strengths, assets, and environmental conditions which promote resiliency or protective factors. Risk-focused approaches are negative in outlook and fail to recognize protective factors at work in a child's environment.

Just "preventing" high risk behaviors is not enough to ensure that youth are ready to assume the responsibilities and challenges of adult life and independent living. Our efforts must begin to focus on the resiliency factors which tell us how the survivors of an "epidemic" differ from those who succumb to the malady. Like Lincoln, those who survive and thrive despite the presence of numerous risk factors may have something to tell us. Our goal should be to support the development of competent, committed and assured youth and we should abandon the inadequate goal of merely producing "problem-free" youth. Wouldn't it be useful to know more about who was headed for serious trouble before the trouble became serious? What is fascinating is this: We already know.

Over the past 20 years, numerous researchers have identified the resiliency and risk factors associated with either positive or negative outcomes. In fact, significant research on predictors of anti-social behaviors have been conducted since as early as 1925 by Sheldon Glueck. These researchers have shed light on the factors which place youth "at risk" of disastrous outcomes as well as revealing the resiliency factors which promote adaptation, well-being, and competence.

REDUCE RISK . . . (continued)

The core of risk and resiliency focused prevention is quite simple and follows a two-pronged approach. To prevent a problem from occurring in the first place, we can

- o identify the conditions that increase the risk of self-destructive behaviors and then either eliminate those factors or reduce their effects; and,
- o identify the conditions that provide some measure of resiliency from problems and support and enhance those factors.

Effective prevention programs attempt to target risk and resiliency factors at multiple levels of the child's environment. The clear message from research is that human development is not influenced by one factor but by a whole mosaic of factors. Children do not grow up in isolation: they grow up in environments. And it is these environments that harbor the causes of poverty, drug abuse, low self-esteem, hopelessness, and boredom. Nature and nurture constantly interact. Various aspects of a child's environment (the family, school, peers, community) affect the individual in different ways. Human development has no single influence--development is shaped by multiple environmental factors working simultaneously together all the way from the individual level up to the institutional level.

Research clearly tells us that the more assets (resiliency factors) an adolescent has, the lower the likelihood that there will be "at risk" behaviors. Dr. Peter Benson of the Search Institute, for example, found that 6th-8th graders with zero to 10 assets had twice as many at-risk indicators as those with 11-20 assets, four times as many as those with 21-25 assets, and ten times as many as those with 23-60 assets.

Despite the presence of multiple risk factors (like in Lincoln's life) most children exhibit a remarkable degree of resiliency. Such resiliency in the face of risk factors has led researchers to ask: "What's right with these children? What protects them?" Studies indicate that resiliency factors such as a close personal relationship with one person, positive experiences at school, and a spiritual commitment can serve as safeguards amidst adversity. Werner and Smith even found that children like Lincoln who came from poor families and had at least four serious risk factors did very well later in life because certain resiliency factors were present.

In future articles, I'll share with you the various risk and resiliency factors that research has determined operate at the various level of a child's environment.

NEW ADAD INTERNS

The Alcohol and Drug Abuse Division acquired two new interns from University of Montana for the Community Youth Activities Program (CYAP). **Craig Ravesloot**, M.A., will provide Program Evaluation and **Joan Sieffert Reiman**, Communication Support. Craig is finishing his doctoral degree in Clinical Psychology; Joan is finishing the Master of Public Administration program.

Program Evaluation Intern

Providing evidence that programs are having some **impact on target populations** is the name of the program evaluation game. Most CYAP sites are now conducting regular program activities as well as doing program evaluation. As this evaluation continues at each site, the issue becomes management and analysis of the data.

To assist with this evaluation data management, Craig will collect Knowledge Attitude Behavior (KAB) surveys and qualitative descriptions of program evaluations. Craig will manage the data base for all of the CYAP sites, oversee data entry of the KAB and will analyze survey results. He is available to provide assistance with evaluation strategies at individual sites. Program directors and staff conducting evaluation activities are encouraged to **contact him as needed, at his home phone (406)543-2661.** The best days to contact him are Thursdays and Fridays.

While Craig has a strong background in research and experimental design, he understands that many programs were not designed with strict experimental analysis in mind. Nonetheless, his knowledge of program evaluation will be useful for collecting the best data possible to demonstrate the efficacy of each program.

The HABIT Newsletter Intern

Joan Sieffert Reiman will intern as editor of THE HABIT to help establish the Regional prevention systems. She will also research and identify community training resources. She has worked in administration of youth job training programs for the Department of Labor and Industry, as a program manager and project monitor/evaluator. She hopes to **gather more input from readers and others involved in youth prevention** and community building. Send news to her at **722 Cherry St., Missoula MT 59802, or call her at (406)728-1170 or through 1-800-457-2327.** The goal of this newsletter is linking up its readers.

CHEMICAL DEPENDENCY COUNSELOR CERTIFICATION
FY 91 (July 1, 1990 - June 30, 1991)

Registered	109
Applications/Submissions	74
Certified	55
Renewed	96
Suspended	37

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Counselor Certification Exam Schedule

Written Exam	Eligibility Documented By
January 11, 1992	November 8, 1991
May 9, 1992	March 6, 1992
September 12, 1992	July 10, 1992

Oral Exam

February 20-21, 1992

June 25-26, 1992

October 22-23, 1992

Tape Reviews	Tapes Due
March 26-27, 1992	March 13, 1992
July 30-31, 1992	July 17, 1992
November 19-20, 1992	November 6, 1992

New Certification Eligibility Rules

New rules became effective March 1, 1991 for Chemical Dependency Counselor Certification. Anyone registering after this date must have met **both the education and the work experience requirements.** The new legislation requires meeting one of the three education requirements in Section (1) **AND** one of the work experience requirements in Section (2) as follows:

Section 1 (Education): A B.A., a B.S., **or** an A.A. degree from an accredited college or university in Alcohol and Drug Studies, Psychology, Social Work, Counseling or a related field; **OR** graduation from a formal Chemical Dependency Counselor training program of at least one year duration.

AND

Section 2 (Work Experience): One year (2,000 hours) of supervised work in Chemical Dependency counseling in a state-approved Chemical Dependency program; **OR** an internship supervised by the college or university and endorsed by the Department; **OR** a similar program recognized under the laws of another state.

For more information on certification, please contact Phyllis MacMillan, Manager, Certification and Reporting, ADAD.

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New Certifications

Congratulations to the newly certified Chemical Dependency Counselors. The following have been certified since the last Habit publication:

Rick Moler
Brad Talbert
Michael Bennett
Chris Emmingham
Alice Brewer
Myron Walking Eagle
Michael L. Charvat
Dan Oberweiser
Thomas Schear
Margaret Mary O'Doherty
Larry Schmitz
Bill Houchin
Charles Palmer
Robert L. Escarcega
Lori Moody-Voss
Melveena R. Malatare
Carol M. Josephson
Mary L. Sarff
Jayme L. Williams
Tyler Coleman
Larry Whiteman
David Donaldson
Rod Walker
Carroll Jenkins
Jan Clark Begger
Vernon R. Mummey
Don Simpson
David Powell
Donna D. Johnson
Jeannette Stangle
Nancy Chalgren
James A. Joachim
Kevin P. Stuart
Robert B. Fry
Ann Johnstone
Judith McGovern
Stephen M. Tobin
Carol J. Wilson

New Certifications (continued)

Cynthia Hughes Wolfe	Cheryl C. Isaacs
Diane Feland	Jackie Cohen
Calvin Jefferson	Darrell Rides At The Door
Steven C. Lockrem	Madeline H. LaValley
Michael Frank	Dirk Gibson
Janice Waltner	Mildred M. Pierce
Polly Eames	Carol Kummer
Donna Skovgaard	Myron L. Littlebird
Lavonne E. Rice	Connie Peterson
Deborah Monteau	Lloyd Smith

POSSIBLE FUTURE TOPICS FOR THE HABIT:

New issues in the development of treatment; managed care vis a vis insurance changes and its effect on new programs (such as outpatient services); treatment of gambling as an addiction; CD programs in Montana; research findings on rural alcohol/drug usage; business community involvement in youth prevention; teen centers - do they work? and other topics of interest to our readers.

The Habit routinely excerpts or reprints articles from national publications on chemical dependency. This service is informational only, to update readers on current opinions and trends in the field. Reprinted articles do not necessarily reflect opinions or policy of the Alcohol and Drug Abuse Division. We welcome opposing viewpoints, letters, or suggestions for notable articles.

WHO ARE OUR READERS?

This newsletter is intended for treatment counselors, program directors, school coordinators, and community prevention workers from the various fields concerned with youth prevention. If you would like to be on our mailing list, write or call us.

ANSWERS AND SOURCES TO DRUG TEST

1. d (USA Today)
2. a (Associated Press interview with former DEA Administrator Lawn)
3. d (Pentagon)
4. a (New York Times)
5. a (Office of National Drug Control Policy)
6. b (Knight-Ridder and State Department)
7. c (Ft. Wayne, Indiana Sentinel 3/16/77)
8. a (Congressional Record; Speech by Senator Biden)
9. a (Congressional Record; Speech by Senator Biden)
10. c (New York Times)
11. c (Newsday)
12. c (The City Paper)
13. c (The Globe)
14. a (Texas State Office of Substance Abuse)
15. b (Texas State Office of Substance Abuse)

Public hearing for state plan, as noted on Page 14, has been rescheduled. Please contact Department.

The Habit routinely publishes articles or excerpts from articles that appear in nationally distributed publications primarily in the field of chemical dependency. Such articles are solely intended to be informational services to our readers and to make them aware of current trends and opinions on issues relating to chemical dependency. Such articles do not necessarily reflect the opinions or policy of the Alcohol and Drug Abuse Division. Suggestions for noteworthy articles or opposing views to articles published are welcomed.

ALCOHOL AND DRUG ABUSE DIVISION

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